	OR MEDICARE & MEDICAID SERVICES			"A" FORM					
TATEMENT OF	FISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY					
	H ONLY A POTENTIAL FOR MINIMAL HARM	_	COMPLETE;						
OR SNFs AND	NFs	345164	B. WING	2/6/2014					
AME OF PROV	VIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE							
CHOWAN RIVER NURSING AND REHABILITATION		1341 PARADIS EDENTON, NO	E RD P O BOX 566						
D REFIX AG	SUMMARY STATEMENT OF DEFICIENCE	CIES							
F 278	483.20(g) - (j) ASSESSMENT ACCURA	CY/COORDIN	ATION/CERTIFIED						
	The assessment must accurately reflect th	e resident's statu	s.						
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.								
	A registered nurse must sign and certify the	hat the assessmen	nt is completed.						
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.								
	Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.								
	Clinical disagreement does not constitute a material and false statement.								
	This REQUIREMENT is not met as evidenced by:  Based on staff interview and record review, the facility failed to code the Minimum Data Set (MDS)  accurately for oral/dental status for two of eight residents (Res#13 and Res #150) sampled for oral/dental status in the MDS.  The findings included:								
	Resident # 13 's admission Minimum I problems. The MDS noted that Resident is	7	-	l/oral					
	On 2/3/2014 at 2:54 PM, in an interview, Resident # 13 was observed to have missing and dark brown stubs of teeth. The resident stated that she needed to see a dentist, and probably needed to go into a hospital to have teeth pulled.								
	In an interview on 2/5/2014 at 3:00 PM, the MDS nurse indicated that there was no dental/oral status in any of the MDS assessments. The nurse stated, "I guess I forgot it."								
	On 2/6/2014 at 11:30 AM, in an interview, the Director of Nursing stated that her expectation would be that the MDS nurse would provide an accurate assessment on a timely basis.								
	Resident #150's five day MDS dated 12/23/2013 indicated no oral/dental status problems. The MDS noted that Resident # 150 was moderately impaired for cognition.								

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT	OF HEALTH AND HUMAN SERVICES	
CENTERS FOR	MEDICARE & MEDICAID SERVICES	

AH "A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WITH	ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE;				
		345164	B. WING	2/6/2014				
NAME OF PROV	IDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE						
CHOWAN R	(VER NURSING AND REHABILITATION	1341 PARADISE RD P O BOX 566						
ID								
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	ES						
F 278	Continued From Page 1							
	On 2/3/2014 at 4:13 PM, Resident # 150 had three or four teeth.	was observed to have r	missing teeth. The resident stated that she	only				
	On 2/6/2014 at 8:00 AM, in an interview 150 had very few teeth.	, the MDS nurse stated	that she must have missed that Resident #	!				
	A review of the dietary supplement assessintake, did receive supplements, and had							
	On 2/6/2014 at 11:30 AM, in an interview the MDS nurse would provide an accurate			at				
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .,	(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING 01 C		
		345164	B. WING		02/	25/2014
	PROVIDER OR SUPPLIER IN RIVER NURSING A	NO REHABILITATION CENTER		STREET ADDRESS, CITY, STAYE, ZIP CODE 1341 PARADISE RD P O BOX 556 EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	9E	(X6) COMPLETION DATE
K 000	INITIAL COMMENT	'S	K 00	0		
K 011 SS⊐D	conducted as per Ti at 42 CFR 483.70(a Health Care section publications. This be construction, one si automatic sprinkler: The Deficiencies de area as follows: NFPA 101 LIFE SAI If the building has a nonconforming build barrier having at lea- rating constructed of addition. Communic corridors and are pro-	termined during the survey FETY CODE STANDARD common wall with a ling, the common wall is a fire st a two-hour fire resistance if materials as required for the sating openings occur only in	K 01	Fire door latch near room 1: will be repaired to latch w activated by fire alarm  Maintenance will check all : doors to ensure that they w: latch when activated by fire alarm  Maintenance will take all no	hen fire ill e	3-12-14
SS=D	A. Based on observ doors near room 134 doors closed upon a 42 CFR 483,70 (a) NFPA 101 LIFE SAF One hour fire rated of fire-rated doors) or a extinguishing system and/or 19.3,5.4 prote the approved automa option is used, the arother spaces by smo	not met as evidenced by: ation on 02/25/2014 the fire if falled to latch when the ctivation of the fire alarm.  ETY CODE STANDARD  construction (with 1/4 hour in approved automatic fire in accordance with 8.4.1 icts hazardous areas. When atic fire extinguishing system teas are separated from the resisting partitions and		Ceiling hole in boiler room be repaired with 5/8 fire retardent sheet rock.  Maintenance will check build ceilings to ensure any holes found are repaired with fire retardent sheet rock or caul	e will ling scara	3-10-14 3-10-14

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulate to continued program participation.

FORM CMS-2557(02-99) Provious Versions Obsolete

Event ID; RNCT21

Facility ID: 923018

If continuation sheet Page 1 of 3

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 -4		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		345164	9. WING			02/	25/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWA	N RIVER NURSING A	ND REHABILITATION CENTER			341 PARADISE RD P O BOX 566 DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	98	(XE) COMPLETION DAYE
K 029	doors. Doors are s field-applied protect	elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K	029	Maintenance will take all compliant issues to the fand safety meeting.		4-11-14
K 025	A. Based on obser was a hole in the co room, 42 CFR 483.70 (a)	s not met as evidenced by: vation on 02//25/2014 there eiling of the out side boiler	V.	038			
SS=D	Exit access is arran	nged so that exifs are readily nes in accordance with section			Map of wiring diagram for secured exits will bee ploty the FACP under glass  Maintenance will take all compliant issues to the fand safety meeting.	non⊶	
K 062 SS=D	A. Based on obsert was no component diagram under glas 42 CFR 483.70 (a) NFPA 101 LIFE SA Required automatic continuously maints condition and are in	s not met as evidenced by: vation on 02/25/2014 there location map nor a wiring ss near the FACP.  FETY CODE STANDARD  sprinkler systems are ained in reliable operating aspected and tested  6, 4.6.12, NFPA 13, NFPA	K	062	Light will be removed in oxygen room and replaced a smaller light so sprink will not be blocked  Maintenance will check apprinklers in to ensure the not blocked.	with ler	3-11-14 -3-11-14 e

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: RNCT21

Facility ID: 923018

If continuation sheet Page 2 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/05/2014 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	LE CONSTRUCTION 0 01 - MAIN BUILDING 01		E SURVEY PLETED
		345164	B. WING		02/2	25/2014
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		SYREET ADDRESS, CIYY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 566 EDENTON, NC 27932		
(X4) ID PREFIX TAG	IEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENYIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X6) COMPLETION DATE
K 062	This STANDARD i	s not met as evidenced by: vation on 02/25/2014 the e 02 storage room was	K 062	Maintenance will take all compliant issues to the fi and safety meeting.		4411444
		sie.				
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FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: RNCT21

Facility ID; 923018

If continuation sheet Page 3 of 3

CENTE	KS FUR MEDICARE	& MEDICAID SERVICES				MID MO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02				E SURVEY IPLETED
		345164	B. WING	-		02/	25/2014
	SUMMARY SYA	ND REHABILITATION CENTER  VIEWEN' OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	1: E	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
K 045 SS=D	Illumination of mea discharge, is arrang lighting fixture (bulk darkness. (This do	AFETY CODE STANDARD  ans of egress, including exit ged so that failure of any single or will not leave the area in less not refer to emergency are with section 7.8.)  19.2.8		045	(A) Lights will be installed building exit outside D&R M station#2 and placed on ger (B) A 2 blub fixture will be outside exit at room 324.  Maintenance will check all side exits for 2 bulb fixtuand ensure they are on general	furses erator e plac out- ires for	ed 4-11-14
K 056 SS=D	A. Based on obser was not enough light exit out side the D is B. There was only at the exit at room 32/42 CFR 483.70 (a) NFPA 101 LIFE SA If there is an autominstalled in accordator the Installation of provide complete coulding. The system accordance with Ni Inspection, Testing Water-Based Fire is supply for the systems are equipped switches, which are building fire alarm is This STANDARD in the systems are equipped to	ratic sprinkler system, it is unce with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the mis properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler are with water flow and tamper a electrically connected to the system. 19.3.5	K	056	Maintenance will take all recompliant issues to the first safety meeting.  A Hi/Low air pressure swit will beplaced on the dry syin D/R side of building.  Maintenance will check to Hi/Low air pressure switch on sprinkler system located boiler room for ABC wing.  Maintenance will take all recompliant issues to the first safety meeting.	ch ala stem	3-31-14 3-31-14
ABORATOR	was no Hi & Low ai	vation on 02/25/2014 there r pressure switch alarm on the DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(XB) DAYE

Any deficiency statement ending with an asterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2867(02-88) Previous Versions Obsolete

Event ID; RNCT21

Facility ID: 923018

If continuation sheet Page 1 of 2

CHITT	TO TON MEDIONICE	G MEDIONID DETAILORD			U	MD MO	. 0938-0391
STATEMEN AND PLAN (	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILDING 02	(X3) DA1	TE SURVEY MPLETED
		345164	B. WING			02	25/2014
	PROVIDER OR SUPPLIER  N RIVER NURSING AN	NO REHABILITATION CENTER		1	TREET ADDRÉSS, CITY, STATE, ZIP CODE 341 PARADISE RD P O BOX 568 DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC'ION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION OA'YE
K 056	Continued From pag dry system . 42 CFR 483.70 (a)	ge 1	K	956			
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FORM CMS-2567(02-89) Previous Versions Obsolete - Event ID: RNCT21

Facility IO: 923018

If continuation sheet Page 2 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/05/2014 FORM APPROVED

IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Lange Parker and	UN UN	NR MO	. 0938-0391
	Contract to the contract of th	A CYPA ARRIVED THE	LE CONSTRUCTION	ON DAT	
	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		E SURVEY IPLETED
	345164	B. WING		02/	25/2014
PROVIDER OR SUPPLIER		, ,	STREET ADDRESS, CITY, STATE, ZIP CODE	O'AL'	LUILUIT
N RIVER NURSING A	D REHABILITATION CENTER				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE	COMPLETION DATE
INITIAL COMMENT	·,	K 000			
conducted as per Til at 42 CFR 483.70(a Health Care section publications. This but construction, one stautomatic sprinkler. The Deficiencies de area as follows: NFPA 101 LIFE SAI If the building has a nonconforming build barrier having at lear rating constructed or addition. Communic corridors and are presented.	ne Code of Federal Register ), using the 2000 Existing of the LSC and its referenced uilding is typeVprotected tory with a complete system.  termined during the survey  ETY CODE STANDARD  common wall with a ling, the common wall is a fire st a two-hour fire resistance of materials as required for the cating openings occur only in oteoted by approved	K 011	will be repaired to latch what activated by fire alarm Maintenance will check all if doors to ensure that they will latch when activated by fire alarm	ire	3–12–14 3–12–14
					4-11-14
A. Based on observedoors near room 13- doors closed upon a	ation on 02/25/2014 the fire 4 failed to latch when the				
NFPA 101 LIFE SAF	construction (with 1/4 hour	K 029	Geiling hole in boller room be repaired with 5/8 fire retardent sheet rock.	will	3-10-14
extinguishing system and/or 19.3.5.4 prote the approved autom option is used, the a	n in accordance with 8.4.1 ects hazardous areas. When atic fire extinguishing system reas are separated from	,	ceilings to ensure any holes found are repaired with fire	nara	3–10–14
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  INITIAL COMMENT  This Life Safety Co- conducted as per Ti at 42 CFR 483.70(a Health Care section publications. This bu- construction, one sta automatic sprinkler.  The Deficiencies de area as follows: NFPA 101 LIFE SAF  If the building has a nonconforming build barrier having at lear rating constructed or addition. Communic corridors and are pre- self-closing fire doors  This STANDARD is A. Based on observed doors near room 13- doors closed upon at 42 CFR 483.70 (a) NFPA 101 LIFE SAF  One hour fire rated of fire-rated doors) or a extinguishing system and/or 19.3.5.4 prote the approved automo option is used, the a other spaces by smo	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is typeVprotected construction, one story with a complete automatic sprinkler system.  The Deficiencies determined during the survey area as follows: NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the contribution wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by: A. Based on observation on 02/25/2014 the fire doors near room 134 failed to Tatch when the doors closed upon activation of the fire alarm. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  K 000  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is typeVprotected construction , one story with a complete automatic sprinkler system.  The Deficiencies determined during the survey area as follows: NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by: A. Based on observation on 02/25/2014 the fire doors near room 134 failed to fatch when the doors closed upon activation of the fire alarm. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	INTIAL COMMENTS  This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is typely protected construction, one story with a complete automatic sprinkler system.  The Deficience determined during the survey area as follows:  NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the continuon wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2.  This STANDARD is not met as evidenced by:  A. Based on observation on 02/25/2014 the fire doors near room 134 failed to latch when the doors closed upon activation of the fire altarm.  42 CFR 483.70(a)  NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.41 and/or 19.3.64 protects hazardous areas. When the approved automatic fire extinguishing system in accordance with 8.41 and/or 19.3.64 protects hazardous areas. When the approved automatic fire extinguishing system in accordance with 8.41 and/or 19.3.64 protects hazardous areas. When the approved automatic fire extinguishing system in accordance with 8.41 and/or 19.3.64 protects hazardous areas. When the approved automatic fire extinguishing system in accordance with 8.41 and/or 19.3.64 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	SUMMARY STATEMENT OF DEPICIENCES  [RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is typeVprotected construction, one story with a complete automatic sprinkler system.  The Deficiencies determined during the survey area as follows:  NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the continuon wall is a fire barrier having at least a two-hour fire resistance rating constructed of rhaterials as required for the addition. Communicating openings occur only in corridors and are proteoted by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by:  A. Based on observation on 02/25/2014 the fire doors hear room 134 failed to latch when the doors closed upon activation of the fire alarm.  Yes the communication of the fire alarm.  Alarmance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm.  Maintenance will take all noncompliant issues to the fire alarm and safety meeting.

'seficiency statement ending with an exterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined/that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days similarly whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/05/2014 FORM APPROVED OMB NO. 0938-0391

	STOR MEDIONING	& MEDICAID SERVICES			0		0.0938-039
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED
		345164	Đ, WING			0.2	/25/2014
	PROVIDER OR SUPPLIER IN RIVER NURSING AN	ND REHABILITATION CENTER	1	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 341 PARADISE RD P O BOX 566 DENTON, NC 27932	1 02	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8F	(X5) COMPLETION DATE
K 029	doors. Doors are se	elf-closing and non-rated or ive plates that do not exceed pottom of the door are	Κo	29	Maintenance will take all compliant issues to the fi		4-11-14
K 038 SS≒D	A. Based on observ was a hole in the cei room. 42 CFR 483.70 (a) NFPA 101 LIFE SAF Exit access is arrang	not met as evidenced by: ation on 02//25/2014 there ling of the out side boiler  ETY CODE STANDARD  ed so that exits are readily as in accordance with section	К 03	38	Map of wiring dangram for secured exits will bee pla by the FACP under glass	ced h	~3 <b>~</b> 6~14
	7.1. 19.2.1				Maintenance will take all compliant issues to the fir and safety meeting.		44711–14
K 062 SS=D	A. Based on observatives no component for diagram under glass 42 CFR 483.70 (a) NFPA 101 LIFE SAF Required automatics continuously maintain condition and are instituted.	ETY CODE STANDARD  prinkler systems are ned in reliable operating	K 06		Dight will be removed in the one of the order of the second and replaced with a smaller light so sprinkle will not be blocked.  Maintenance will check and sprinkless in to ensure the not blocked.	th r viar	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/05/2014 FORM APPROVED OMB NO. 0938-0391

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NAME OF	PROVIDER OR SUPPLIER	·		1		TREET ADDRESS, CITY, STATE, ZIP CODE	[ 02	/25/2014
CHOWA	N DIVED MUDDING A	VD OFILEDIA	(90 a refraction to the section	]		341 PARADISE RD P O BOX 568		
	N RIVER NURSING A					DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DE MUST BE PREC SC IDENTIFYING	EUSD BA CITT	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	Continued From pa This STANDARD is A, Based on obser sprinkler head in the blocked by a light fir 42 CFR 483.70 (a)	s not met as vation on 02/ e 02 storage	25/2014 the	Ko	62	Maintenance will take all r compliant issues to the fir and safety meeting.		441114
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PRINTED: 03/05/2014 EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED MAR 1 9 2014 OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPI, IER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 02 - BUILDING 02 STRUCTION SECTION COMPLETED 345184 B. WING 02/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 586 CHOWAN RIVER NURSING AND REHABILITATION CENTER EDENTON, NC 27932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH D'EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY (Δ) Lights will be installed on K 045 NFPA 101 LIFE SAFETY CODE STANDARD K 045 building exit outside D&R Nurses 4-11-14 SS≃D station#2 and placed on generator Illumination of means of egress, including exit (B) A 2 blub fixture will be placed discharge, is arranged so that failure of any single 4-11-14 outside exit at room 324. lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) Maintenance will check all outside exits for 2 bulb fixtures by and ensure they are on generator 4-11-14 Maintenance will take all noncompliant issues to the fire and 4-11-14 This STANDARD is not met as evidenced by: A. Based on observation on 02/25/2014 there safety meeting. was not enough light for the exit pathway at the exit out side the D & R Nurses Station #2. B. There was only a one (1) bulb fixture out side the exit at room 324 42 CFR 483,70 (a) NFPA 101 LIFE SAFETY CODE STANDARD K 056 K 056 A Hi/Low airo pressure switch alarm SS≓D will beplaced on the dry system 3-31-14 If there is an automatic sprinkler system, it is in Bir side of building. Installed in accordance with NFPA: 13; Standard for the Installation of Sprinkler Systems, to Maintenance will check to ensure provide complete coverage for all portions of the 3-31-14 Hi/Low air pressure switch is building. The system is properly maintained in on sprinkler system located in accordance with NFPA 25, Standard for the boiler room for ABC wing. Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully Maintenance will take all nonsupervised. There is a reliable, adequate water compliant issues to the fire and 4411-14 supply for the system. Required sprinkler systems are equipped with water flow and tamper safety meeting. switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 02/25/2014 there was no Hi & Low air pressure switch alarm on the (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

rotoriaisabel 'eficiency statement ending with an esterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that saleguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made evailable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 02 - BUILDING 02 345164 9, WING 02/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 566 CHOWAN RIVER NURSING AND REHABILITATION CENTER EDENTON, NC 27932 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION Ю (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) K 056 Continued From page 1 K 056 dry system. 42 CFR 483.70 (a)